Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for date of service 02/19/01?

   b. The request was received on 02/11/02.

II. EXHIBITS

1. Requestor, Exhibit 1:

   a. TWCC 60 and Letter Requesting Dispute Resolution dated 02/28/02
   b. HCFA's
   c. EOB
   d. EOBs from other Carriers
   e. Medical Records
   f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit 2:

   a. TWCC 60 and Response to a Request for Dispute Resolution 02/13/02
   b. HCFA's
   c. Audit summaries/EOB
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (4) or (5), the carrier representative signed for the copy on 04/03/02. The response from the insurance carrier was received in the Division on 04/13/02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of Medical Dispute is reflected as Exhibit #3 of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor:

   The Provider... "charges the above-referenced services at a fair and reasonable rate. Specifically, these rates are based upon a comparison of charges to other Carriers and the amount of reimbursement received for these same or similar services." The provider is seeking additional reimbursement in the amount of $13,477.68 for the date of service 02/19/01.

2. Respondent:

   The carrier denies additional reimbursement of $13,477.68 for date of service 02/19/01 as M-"THE REIMBURSEMENT FOR THE SERVICE RENDERED HAS BEEN DETERMINED TO BE FAIR AND REASONABLE BASED ON BILLING AND PAYMENT RESEARCH AND IS IN ACCORDANCE WITH LABOR CODE 413.011(B)."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible is 02/19/01.

2. The Provider billed the Carrier $14,373.10 for the date of service 02/19/01.

3. The Carrier paid $545.20 for the disputed date of service 02/19/01.

4. The Provider is seeking additional payment in the amount of $13,477.68.

5. The services provided by the Requestor include such items as anesthesia and lab services, pharmaceutical products, medical and surgical supplies, sterile supplies and EKG.

V. RATIONALE

Medical Review Division's rationale:

The medical documentation indicates the services were performed at an ambulatory surgical center. The provider has submitted additional reimbursement data (EOBs from various carriers) for similar services to patients of an equivalent standard of living in their geographical area. This information does provide some evidence of a fair and reasonable charge.

However, the carrier has submitted documentation asserting that they have in fact paid a fair and reasonable reimbursement. Respondent has submitted an explanation of their methodology. Per Rule 133.304 (i), "When the insurance carrier pays a health care provider for treatment(s) and /or service(s) for which the Commission has not established a maximum allowable reimbursement, the insurance carrier shall:

"develop and consistently apply a methodology to determine fair and reasonable reimbursement amounts to ensure that similar procedures provided in similar circumstances receive similar reimbursement; explain and document the method it used to calculate the rate of pay, and apply this method consistently; reference its method in the claim file; and explain and document in the claim file any deviation for an individual medical bill from its usual method in determining the rate of reimbursement."

The Carrier has explained their methodology as follows:

The Carrier's methodology incorporates information from:

1) U.S. Department of Health and Human Services. Health Care Financing Administration. "Ambulatory Surgical Center 1994 Medicare Payment Rate Survey" http://www.hcfa.gov/medicare/ascread.htm, August 13, 1998.
1) U.S. Department of Health and Human Services, Health Care Financing Administration, "Medicare Program: Update of Ambulatory Surgical Center Payment Rates Effective for Services on or after October 1, 1997" (Notices) Federal Register. 63FR19FE98 8462-8465.

The Carrier indicates that Medicare classifies surgical procedures into 8 groups. All CPT Codes within the same grouping are paid at the same rate (group rate). That reimbursement allowed by Medicare is then multiplied by 20%. This is the copay amount under Medicare that the patient pays and which is not allowed by Texas Workers' Compensation Act. The group rate and the copay amount are added together to determine the total payment.

The Carrier notes that regional and geographic differences are taken into account by Medicare. However, the Fund believes that by taking the group rate and adding in the copay amount, that its reimbursement is higher than Medicare's rate of reimbursement.

Exhibit 2 is a copy of the ASC groups as indicated by the Federal Register, 12/14/93. The Carrier has submitted additional information to further support its methodology. Exhibit 3 is a List of Percentage Payments by Texas WC Insurances.

Due to the fact that there is no current fee guideline for ASCs, the Medical review Division has to determine, based on the parties' submission of information, who has provided the more persuasive evidence. As the requestor, the health care provider has the burden to prove that the fees paid were not fair and reasonable. In this case, the provider has submitted EOBs from other carriers that indicate those carriers paid 87% of the billed charges. The Requestor has also submitted information that indicates that there are other carriers who do not reimburse 100% of the billed charges but in fact pay anywhere from 13% to 100% with an average 84%. There is no way to determine what the other carriers' methodologies are rated on.

However, the Carrier has provided their methodology, as required by Rule 133.304 (i), along with information indicating that other ambulatory surgical centers have accepted their payments, which is sufficient to establish the amount requested by the requestor is not fair and reasonable even though the entire methodology may not necessarily be concurred in by the Medical Review Division. Therefore, **no** further reimbursement is recommended.

The above Findings and Decision are hereby issued this 17th day of April 2002.

Michael Bucklin, LVN
Medical Dispute Resolution Officer
Medical Review Division